DENTAL Enrollment Form

PLAN YEAR 7/1/2020 – 6/30/2021

Please check reason for completing this form					
☐ New Enrollment ☐ Annual Enrollment ☐ Change ☐ Reinstatement Effective Date: / /	If this is a Change, please indicate type of Change and reason below. ☐ Cancel Employee ☐ Termination ☐ Other – Reason:	☐ Add Dependents ☐ Birth ☐ Marriage ☐Adoption ☐ Other – Reason:	☐ Cancel Dependent(s) ☐ Marriage ☐ Divorce ☐ Change in Student Status ☐ Other – Reason:	☐ Address Change ☐ Name Change	☐ Transfer to COBRA Qualifying Event ☐ Termination ☐ Reduction in Hours ☐ Divorce ☐ Death ☐ Dep. Status Change ☐ Other – Reason:

Employer Information – To Be Completed By Employer				
Employer Name: **City of Greenfield**	Employee's Date of Hire:	Location Code: Town **0000** GCET **0004** School **0001** FHECT **0003**	Location:	Scheduled Weekly Hrs:
Guardian Dental 357735	Job Title		Department	

Employee Information				
Employee Name: Last First M.I.	Social Security #	Home Phone:	Work Phone:	
Address: Street Apt. City State Zip Code	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed	Gender:		

Dental Selection Or Waiver - Guardian	***Dental Coverage***	
☐ **WAIVE COVERAGE**	☐ **$1,000 Base Plan** ☐ **$2,000 Buy Up Plan**	☐ **Employee** ☐ **Emp. + Spouse** ☐ **Emp. + Children** ☐ **Emp. + Family**

Employee & Dependent Information (Identify yourself and any dependents you want covered, dropped or changed)

Name (Last, First, MI)	Drop Add	Sex	FT Student	Birth Date	Soc. Sec. #
Self	☐ Drop ☐ Add	☐ M ☐ F			
Spouse	☐ Drop ☐ Add	☐ M ☐ F	☐ Y ☐ N		
Child	☐ Drop ☐ Add	☐ M ☐ F	☐ Y ☐ N		
Child	☐ Drop ☐ Add	☐ M ☐ F	☐ Y ☐ N		
Child	☐ Drop ☐ Add	☐ M ☐ F	☐ Y ☐ N		

Other Insurance Coverage

Are you or your dependents covered by other group dental coverage? ☐ Yes ☐ No If yes, please complete the following information.

Name of Person	Employer Name,	Insurance Co.Name,	Type of Coverage	Policy Number
			☐ Dental	

DISCLAIMER: Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet. If coverage is waived and you later decide to enroll, lat entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request. I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

FRAUD STATEMENT: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:

1) Apply for the benefits designated for which I am eligible under my employer's plan with Health New England, Guardian and my employer's Section 125 Cafeteria Plan. 2) Represent that all of the information on this Enrollment/Change Form is complete, correct and true. 3) Agree that a photocopy of this Enrollment/Change Form shall be considered to be valid and effective as the original. 4) Understand that if I have waived enrollment in any benefits for which I am eligible, and later wish to apply for the benefits I have waived, my application for enrollment in those benefits may be declined, or I may have to furnish at my own expense, evidence of insurability which is satisfactory to the Insurance Companies and my Employer. 5) Authorize any required deductions from my earnings. 6) Understand that I must meet all the eligibility requirements of my employer's plans to remain insured.

Employee Signature: _____ **Date**: _____

Authorized Employer Signature:: _____ **Date**: _____

Internal Use Only

Census ❒ _____ Sent Guardian ❒ _____ Payroll ❒ _____ COBRA spreadsheet ❒ _____

WebCOBRA ❒ _____ Town Ret . ❒ _____ Ret. Teacher ❒ _____ (ck reason above in changes)

Rev 4.10.20